# Rapid Review in Personality Disorders

## Characteristics of individuals with personality disorder in community, clinical and forensic settings; treatment approaches to personality disorder; good practice, and staff characteristics and compositions.

**Report commissioned by the HSC Research & Development Division, Public Health Agency; in conjunction with the Health and Social Care Board, and the Department of Health, Social Services and Public Safety (Northern Ireland)**

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# Executive Summary

Reports by the Bamford Review of Mental Health and Learning Disability highlighted the lack of specialist services for individuals with personality disorder in Northern Ireland, and recommendations to rectify this have been heard and built upon. At present, specialist services for personality disorder in Northern Ireland are being planned and developed in accordance with the Northern Ireland Personality Disorder Strategy (DHSSPS, 2010). In this context, the present review addresses questions that have been raised in order to inform and highlight issues and evidence pertinent to the establishment and delivery of these services in terms of prevalence, treatment and good practice.

Personality disorders are enduring and deep-rooted patterns of behaviour in dealing with the self and others that cause distress and difficulties across a range of situations and functioning. The American Psychiatric Association provides guidelines for the diagnosis of ten personality disorders, and the World Health Organisation describes eight. Reformulations of these guidelines are underway and are proposed to include pathological personality trait representations. Personality disorders are often present alongside other mental disorders, and particularly when undetected or unrecognised, cause difficulties in treatment allocation, adherence and suitability. Severe difficulties in interpersonal functioning cause distress to clients and their families and carers and to service providers. Specialist treatment is vital as many interventions for comorbid disorders are hindered or counterproductive when personality disorder is present.

As well as biological and genetic factors, adverse childhood experiences are associated with development of personality disorders and other mental health issues. This is particularly relevant to Northern Ireland as there are high levels of trauma associated with the conflict.

## Recommendations/Areas for Consideration

These recommendations are based on the findings from the review. The recommendations cover research, treatment and the development of services. Prioritisation will depend on the resources available, prevalence, cost effectiveness, and level of need.

1. Research into prevalence rates and existing treatment pathways for personality disorder in Northern Ireland should be undertaken.

2. Planning, evaluation and service protocols for personality disorder services in Northern Ireland should reflect and inform proposed changes to legislation in Northern Ireland and anticipate proposed changes in the DSM and ICD personality disorder guidelines.

3. A full economic evaluation of costs of personality disorder, or evaluation of service use by individuals with personality disorder across health and social care, housing,

policing and other agencies would provide baseline figures to establish and evaluate targets and potential intervention strategies taking into account the economic impact of introducing specialist services.

4. Training, awareness and support should be provided to staff in mental health services and other services/agencies to ensure that communication with clients is appropriate and this should include before and after measures of awareness and attitudes for the purpose of evaluation. Dedicated individuals with the expertise to assess personality disorders and complete a comprehensive psychological assessment should be identified within existing mental health / Primary Care Liaison services.

5. Integrated pathways for care should be agreed and developed for health, forensic and prison settings, and implemented from an early stage in service delivery.

6. Clear transition pathways should be developed for crossovers between community health and social care and prison, between child and adolescent mental health services and adult mental health services, and for the end of treatment, including risk management strategies and protocols.

7. A range of therapeutic interventions should be developed and made available as part of individual treatment planning, and universal and patient-specific outcome measurements should be included in treatment planning and assessments for evaluation purposes. (At present the National Institute for Clinical Excellence [NICE] provides treatment guidelines only for Borderline and Antisocial personality disorders, and medication is not recommended for individuals with these disorders except for the treatment of other co-occurring clinical disorders.)

8. Workforce planning in the area of personality disorder should include substantial focus on the suitable personal qualities of staff, and the provision of good clinical supervision and support management systems for staff.

9. Specialist personality disorder teams should include a broad range of disciplines and skills that can be used to provide expertise and choice of therapy treatments, interventions and skills training.

10. Clear and immediate support should be provided to ensure speedy set-up and implementation of specialist personality disorder teams in Northern Ireland.

# SECTION A

# Introduction and Northern Ireland context

### *General definition of personality disorder*

Current psychiatric diagnostic guidelines provided by the American Psychiatric Association (APA) state that personality disorders are characterised by an "*enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment*" (DSM-IV-TR; APA, 2000). This guideline provides a list of 10 personality disorders, measured from a total of 79 criteria. The personality disorders are: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, obsessive-compulsive and dependant. The World Health Organisation also provides diagnostic guidelines for eight personality disorders, which are closely linked to DSM formulations. The eight personality disorders included in the ICD-10 (WHO, 1992) are: paranoid, schizoid, dissocial, emotionally unstable (impulsive type and borderline type), histrionic, anankastic, dependent and anxious. However the concept of personality disorder is historically fraught with difficulties. For example the validity of various diagnoses, evidence of high co-morbidity, differences in perceived treatability and how services should be organised to best meet the need of those with personality disorder are well documented in literature. This client group is not homogeneous; there may be as much variation in the presentation of personality disorder as exists across all other areas of mental illness.

Reformulations of the personality disorder sections of psychiatric nomenclatures are under development. For example, proposals for the fifth edition of the DSM (APA, 2011) include the removal of paranoid, schizoid, histrionic and dependant personality disorder formulations and the inclusion of 'personality disorder trait specified' that encapsulates dysfunctional trait manifestations of personality listed as negative affectivity, detachment, antagonism, disinhibition v compulsivity, and psychoticism (APA, 2011). Initial proposals for the new edition of the ICD include the categorisation of personality as trait domains of asocial, emotionally unstable, obsessional (anankastic), anxious/dependant, and dissocial (Tyrer et al, 2011). Although such changes will have implications for clinical practice, it is unlikely that treatments for management of personality disorder will change, as most treatments, interventions and outcome measures are not targeted at specific personality disorders but at the particular dysfunctional presentations in each individual. These manifestations will hopefully be better captured in the anticipated reformulations.

Individuals with PD often find it difficult to access and remain with mental health services. Lack of specialist personality disorder services and lack of knowledge and awareness often results in short-term treatments or interventions, and/or pharmacological treatments which are contrary to guidelines published by the National Institute of Clinical Excellence (NICE). At present, NICE clinical guidelines are provided for only two personality disorders – antisocial and borderline (NICE, 2009a; 2009b).

Individuals with personality disorders have been branded as difficult to treat, resulting in the frustration and disillusion of clients due to lack of understanding, empathy and provision of specialist services.

There are higher costs associated with individuals with personality disorder. In 2008/2009, £1.76 million was allocated to provide specialist treatment for 15 people in other parts of the UK (DHSSPS, 2010). Yet as well as cost reduction associated with the provision of local specialist services, savings across a range of services and sectors are likely, such as accident and emergency departments, inpatient mental health beds, housing and policing (Crawford, 2007).

Finding a lack of specialist personality disorder services in Northern Ireland, the Bamford Review of Mental Health and Learning Disability Strategic Framework for Mental Health Services report (DHSSPS, 2005) recommended the development of specialist services in Northern Ireland that should include multidisciplinary teams for providing training and support to other services as well as residential and day treatment services. In addition, the Bamford Review of Forensic Services (DHSSPS, 2006) recommended basic training for individuals in contact with or working with people with personality disorder, through a regional training and supervision strategy, as well as the provision of a residential secure service, outpatient and day patient services provided by prisons, and provision of access to assessment and treatment for offenders with personality disorder. Currently, according to the Service Framework for Mental Health and Wellbeing (DHSSPS, 2011), individuals with personality disorder should receive a mental health risk assessment and referral to specialist assessment and be provided with access to a range of appropriate treatments and care, education, advice, support and management delivered by a regional personality disorder service. A Personality Disorder Sub Group has been established, the most recent Northern Ireland Strategy for Personality Disorder was published in 2010 (DHSSPS, 2010) and recruitment is underway for key staff across the Health and Social Services Trusts.

The legislation surrounding mental health in Northern Ireland has not changed since 1986, and some of it is not in line with changes made in legislation across England and Scotland. The proposed Mental Capacity (Health, Welfare and Finance) Bill for Northern Ireland will include personality disorder in the new definition of mental disorder, resulting in individuals with a sole diagnosis of personality disorder no longer being excluded from assessment and treatment service provision. However, the Personality Disorder Strategy (DHSSPS, 2010) does not refer to the proposed framework for the bill (DHSSPS, 2009).

### *Possible impact of the Troubles*

Specifically in Northern Ireland, due to the trauma and conflict of the Troubles and the after-effects, there is a higher rate of mental illness. In a report by the Royal College of Psychiatrists (RCP, 2006), an estimation of 21% and 29% higher mental health need in men and women respectively is reported for Northern Ireland compared to England; and 20% of young people experience higher stress, with twice the number of negative life events compared to adolescents elsewhere, and spend or have spent formative and developmental years with confrontation and violence in their communities.

This is reflected in an examination of psychological trauma and related disorders in the Northern Ireland population where Ferry, F., Bolton, D., Bunting, B.P., and McCann, S (2008) reported that over 16% of individuals who experienced a conflict related event met criteria for post-traumatic stress disorder. Borderline personality disorder is highly comorbid with PTSD, and childhood trauma and violence is strongly associated with antisocial personality disorder (Axlerod, Morgan and Southwick, 2005). Prevalence figures for various mental health conditons have been reported by Bunting, B.P., Murphy, S.D., O'Neill, S.M, and Ferry, F. R., (2011), and a comparison of these figures with those reported elsewhere can be found in Kessler et al (2011). Mental health prevalence figures for most conditions are at the high end when compared with those from other societies.

Although each individual suicide will contain many influences and processes that are unique to those who chose to end their lives, it is acknowledged that societal and cultural influences do play a role. It is noteworthy that while official suicide rates in England, Wales and Scotland have decreased in the past ten years, Northern Ireland has seen a reverse trend for both males and females. In particular, males in Northern Ireland show the greatest increase in suicide rates (Samaritans, 2012), suggesting unique cultural or societal influences which are negatively affecting the emotional wellbeing and personality development in both men and women.

The aftermath of the Troubles includes continuing mental health difficulties which may also affect subsequent generations through parenting, family and community environments.

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# SECTION B

# Purpose of the Review and methodology used

The purpose of the current review is to bring together recent and relevant literature regarding personality disorders based on the scope provided by commissioners.

### *Research questions*

The call for a rapid review in personality disorders was formulated in terms of three broad questions.

1) What are the groups and characteristics of people with personality disorders within community, clinical and forensic settings?
2) What are (a) the treatment approaches for personality disorders in community and prison settings, and (b) their outcomes?
3) What are the staff compositions and characteristics of existing good practice specialist personality disorder services elsewhere?

The research team discussed the proposed layout of the review and deemed it more readily discernible if the subject area was divided into three broad sections relating to the three review questions.

### *Literature search*

The literature review was carried out using a range of databases, snowballing techniques and hand searching of grey literature and research team resources. The electronic databases used were Medline, Embase, CINAHL, Cochrane Library, TripPlus and Zetoc. Due to the short term nature of the review, a 'review of reviews' method of prioritising evidence-based literature for inclusion was implemented where relevant. Search terms utilised within each database were 'personality disorder*' with, 'meta*analysis', 'literature review', 'evidence', 'trial', 'evaluation', 'forensic' and 'crime', 'criminology' and 'criminal', 'clinical' and 'community'. All papers that provided information regarding the treatment, correlates or aetiological characteristics of personality disorder were included, prioritised by meta-analysis or review status. These search terms were selected because they referred to the specific methodologies we were interested in (reviews and meta-analyses), the disorders themselves and the three settings of interest (community, clinical and forensic).

Review team members also provided literature and information that they deemed relevant to the review, and one member of the team viewed abstracts and identified relevant papers for inclusion. Snowballing techniques were also employed when other relevant literature was identified. This approach was adopted in order to utilise efficiently the expertise of each individual team member given the review's time constraints.

As indicated later in the review, evidence of co-morbidity of other mental disorders with personality disorders was high. Furthermore, there are large numbers of pharmacological and psychological therapies provided for individuals with personality disorder, yet overall analysis of these are difficult due to the wide range of diagnostic tools and outcome measures used that cannot be easily compared. As a result, although there are many published papers reporting clinical trials, evidence for the generalizability of results is difficult to establish.

Evidence of audit and outcomes in terms of good practice personality disorder service provision was meagre. However the search revealed three particularly useful resources for information – the Scottish Personality Disorder Network, the 'Learning the Lessons' report on 11 pilot personality disorder services in England (Crawford, 2007) and the evaluation of three pilot forensic personality disorder services in England (Moran et al., 2008).

### *Limitations of the current review*

The broad scope of the review and the short time frame associated with it dictated the use of review and meta-analysis level evidence. While this level of information may provide more robust evidence, lack of information for specific personality disorders and specific symptoms (such as self-harm) resulted.

For information on best practice, information was provided from qualitative reviews of pilot studies in England. Quantitative evidence in terms of auditing and service impact would have been preferred but was lacking. In addition, information from the pilot study reviews was deemed relevant in terms of NHS service provision; and also in the light of the current status in Northern Ireland in which specialist personality disorder services are being planned and issues of development and set-up are pertinent.

The current review does not include information on childhood or adolescent personality disorders. Some research has been published regarding this age group; however it remains controversial in the field as personality is generally viewed as still maturing until late adolescence and early adulthood, therefore personality disorders may be difficult to distinguish from changes and developmental challenges in childhood and adolescence.

The lack of information and evidence of personality disorders in Northern Ireland's clinical, general and prison populations is a drawback for the current review, and findings may not be fully generalizable to Northern Ireland due to the possibility of the impact of the 'Troubles' on mental health in general and in the development of personality disorders in particular, as trauma and violence are associated with specific personality disorders.

Users' experiences of treatment and care for personality disorders can be understood using qualitative research methods. The examination of users' experiences is outside the remit of this review. Readers are referred to the study by Turner, Neffgen and Gillard launched at the British and Irish Group for the Study of Personality Disorder Annual Conference on Understanding Recovery.

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# SECTION C

# Prevalence and characteristics of individuals with personality disorder

Given that there is a lack of information regarding the prevalence of personality disorders for Northern Ireland, prevalence rates and information regarding personality disorder have been sourced from other geographical areas. In terms of proximity and relevance, studies based in England provide the closest information, however evidence from other areas such as the USA, Australia, New Zealand and Europe are included to provide a Western yet global perspective.

## *Prevalence in general populations*

Epidemiological studies have provided overall estimations of personality disorders in general populations. A national survey of private households in England, Scotland and Wales, carried out in 2000 (Singleton et al., 2001) provides weighted prevalence rates of 4.4% for any personality disorder (Coid, Yang, Tyrer, Roberts and Ullrich, 2006). The World Health Organisation's World Mental Health Surveys have produced an overall estimated prevalence rate of 6.1%, with 2.4% prevalence in Western Europe (Belgium, France, Germany, Italy and Spain) and 7.6% in the USA (Huang et al., 2009). In Australia, a national survey of mental health and well-being found prevalence rates of specific personality disorders between 0.2% and 1.7%, with 93.4% of the sample reported as having no personality disorder. There are currently no figures for the prevalence of personality disorders in NI. Given the recent history of violence and the absence of the identification of developmental risks of personality disorder, we might speculate that the rates are high in NI. It was thought that the paramilitary threat hindered the reporting of traumatic events, and limited help seeking behaviour. Furthermore, a culture of avoidance and denial may have resulted in traumatised parents being unable to recognise signs of trauma in their children (Ghigliazza, 2008).

Among the homeless population, rates of mental disorders are high, including personality disorders. A recent systematic review and meta-regression analysis of prevalence of mental disorders among the homeless in western countries found a pooled prevalence of personality disorders at 23.1%, with a range between 2.2% and 71.0% across fourteen surveys (Fazel, Khosla, Doll and Geddes, 2008). This has consequences for many government agencies and third sector organisations.

## *Clinical settings*

The general population rates of personality disorder provide estimates prevalence in the general population and provide a useful benchmark for comparisons. In terms of clinical and forensic populations, the rate of personality disorder is much higher. As well as higher prevalence rates for personality disorder within such populations, there is widespread co-occurrence of two or more personality disorders as well as co-morbidity with other clinical

mental disorders. Furthermore, there is evidence of professional negative beliefs and attitudes towards personality disorders and the individuals presenting with them (Dixon-Gordon, Turner and Chapman, 2011; James and Cowman, 2007) due to the specific coping, social and insight difficulties involved in such disorders. As a consequence of this, and the difficulty in providing evidence-based treatment specifically for personality disorders, diagnoses and acknowledgement of them can be sometimes abandoned in favour of the mainstream mental illnesses, resulting in the likelihood of prevalence underestimation. Within clinical populations, individuals with personality disorders are likely to remain in services long-term, as these disorders often influence and disrupt treatment, particularly when the main diagnosis is another mental disorder. Rates of personality disorder within clinical in-patient and out-patient populations range from between 30% to 67% (DHSSPS, 2010; Moran, 2008; Zimmerman, Rothschild and Chelminski, 2005). Course of treatment adherence is often influenced by the specific difficulties within personality disorders, and the presence of co-morbidity with other mental disorders and the increased levels of self-harm also contribute to 'revolving door' type situations in mental health care settings, and consequently results in almost double the economic costs (Barrett, 2005; Knapp, 2008).

### *Forensic and prison populations*

High economic costs have also been found with personality disorder in forensic and prison settings; within hospital-based sites, the cost per place per year was between £192,129 and £223,237; in prison-based sites between £67,552 and £117,879; and NHS medium secure services at £200,000 (Barrett, 2005; Knapp, 2008).

Prevalence rates in prisons are reported as between 60% and 80% (DHSSPS, 2010). In a survey of prisoners in England and Wales (Singleton et al., 1998), 65% prevalence rate for personality disorder was found, with the most prevalent diagnosis of antisocial personality disorder in male and female remand and sentenced prisoners, followed by paranoid personality disorder in men and borderline personality disorder in women (Coid et al., 2009). A systematic review of mental disorders in 23,000 prisoners across the world (Fazel and Danesh, 2002) found a personality disorder prevalence rate of 65% for males and 42% for females. It is unclear whether these figures also apply to Northern Ireland given that the profile of the prison population may be affected by the civil conflict.

There are two high secure units based within the prison system for 'Dangerous and Severe Personality Disorder', (a name that incorporates the most severe forms of personality disorder within the forensic setting, but not included in current DSM and ICD psychiatric guidelines), and wards specialising in treatment of personality disorder in three high secure hospitals in the UK (Craissati et al., 2011).

### *Characteristics and correlates of personality disorders*

There is difficulty in isolating personality disorders from other mental disorders for examination of correlates, aetiology and treatment outcomes, resulting in inconsistent

findings. Levels of comorbidity and combinations of comorbid disorders may be vital for identifying difficulties and treatment planning. Anxiety, affective and mood disorders as well as major depression and substance use disorders are associated with personality disorders. There is evidence that NI has a high prevalence of these mental disorders and again this may be associated with the recent history of conflict (Ferry et al., 2009). Furthermore, low premorbid IQ is associated with development and hospitalized treatment of personality disorder (Urfer-Parnas et al., 2010; Moran et al., 2009).

Coid, Yang, Tyrer and Roberts (2006) provide details of characteristics of people with personality disorder based on diagnosis groupings for DSM Clusters A, B and C. Cluster A consists of paranoid, schizoid and schizotypal personality disorders; Cluster B is made up of borderline, narcissistic, histrionic and antisocial; and Cluster C consists of avoidant, dependant and obsessive-compulsive personality disorders. In the household survey in England, Scotland and Wales, Cluster A personality disorders were more prevalent in the unemployed, lower social class and in those separated or divorced. Cluster B disorders were more likely in males, younger age groups, and in individuals separated or divorced, and in lower social class. Cluster C disorders were associated with individuals who are economically inactive (including students). There were high levels of comorbidity found across Clusters as well as with other mental disorders. Cluster B personality disorders were associated with anxiety and affective disorders as well as functional psychosis, and Cluster C with affective and anxiety disorders. In addition, Cluster A diagnoses were three times more likely to have been associated with local authority care before age 16. Criminal conviction, prison time and local authority or institutional care were more likely in Cluster B diagnoses, and psychotropic medication and counselling more likely with Cluster C personality disorders.

From a national comorbidity survey in the USA, Lenzenweger, Lane, Loranger and Kessler (2007) indicate that all three personality disorder clusters are associated with anxiety, mood, impulse control and substance disorders, with highest odds ratios found with Cluster B personality disorders. Within this cluster of disorders, the young, unemployed and poorly educated provide highest rates of diagnoses. Cluster A diagnoses have a 5.2 prevalence rate, and authors indicate that higher rates in the epidemiological sample than in clinical samples indicate that individuals with these personality disorders are less likely to seek treatment. No differences for diagnoses across clusters were found for gender, race or marital status.

In another large representative study in the USA, Trull et al. (2010) found no gender difference for schizotypal personality disorder, yet found males were more likely to be diagnosed with schizoid, antisocial and narcissistic personality disorders; and females more likely to have paranoid, borderline, histrionic, avoidant, dependent and obsessive compulsive personality disorders. Alcohol dependence is very strongly related to any personality disorder diagnosis in this study, with approximately half of those with antisocial, histrionic and borderline personality disorders also reporting lifetime alcohol dependence. Drug dependence is most highly related to histrionic, dependant and antisocial personality disorders. Furthermore, in this study, all DSM personality disorders were found to be associated with high levels of perceived stress, less social support, suicide attempts, interpersonal difficulties and problems with legal authorities.

The numbers of specific personality disorders and their differing presentations make it difficult to generalise characteristics and correlates in meaningful ways. Specific details are required in order to provide information useful for clinical, forensic and policy-informing use. For example Lobbestael, Arntz and Bernstein (2010) examined five forms of childhood maltreatment with the 10 DSM personality disorders, finding that different forms of childhood harm have different effects on personality pathology.

Most literature pertaining to personality disorders focuses on the two most prevalent and widely-researched disorders of borderline and antisocial. In clinical and forensic settings, these personality disorders are most prevalent, and involved in high levels of personality and mental disorder comorbidity.

Borderline personality disorder involves affect dysregulation, behaviour dysregulation and disturbed relations symptoms (Chmielewski et al., 2011), and is associated with high rates of self-harm, suicidal behaviour and suicide completion. In the USA, 80% of individuals diagnosed with borderline personality disorder engage in suicidal behaviour, and 4%-9% complete suicide. There are also high levels of comorbidity with other mental disorders (85%), the most prevalent being major depression, anxiety disorders, eating disorders, substance abuse and post-traumatic stress disorder (NIMH, 2008).

Developmental issues have been associated with borderline personality disorder, in particular childhood abuse, neglect and trauma. It is now also widely accepted that borderline personality disorder occurs as a result of heredity, genetics, environmental risk factors and traumatic experiences. Early vulnerability may be expressed as impulsivity and/or heightened emotional sensitivity (Crowell, Beauchaine and Linehan, 2009).

Neuroimaging shows differences in brain function and structure in individuals with borderline personality disorder compared to those without. Findings suggest that dissociation symptoms are correlated with size abnormalities of the superior parietal cortices in the brain; emotional control functions are associated with frontolimbic dysfunction and abnormality in prefrontal brain regions; and affective instability is linked with less activation of cognitive control regions in individuals with borderline personality disorder (Leichsenring et al., 2011). In a review of the hypothalamic-pituitary-andrenal axis in borderline personality disorder, Zimmerman and Choi-Kain (2009) found results that varied in terms of comorbidity with other mental disorders. Depression, post-traumatic stress disorder, dissociative symptoms and a history of childhood abuse are important correlates due to the differences in stress reactivity.

Antisocial personality disorder is often associated with crime and forensic settings, which is unsurprising given that one of the criteria for this disorder involves the presence of unlawful behaviour. Within forensic settings, antisocial personality disorder is often perceived as a less severe form of psychopathy. However it should be noted that psychopathy appears to be associated with symptoms from across a number of specific personality disorders, and differs in terms of an aggressive or antagonistic way of dealing with or relating to others (Blackburn, 2007). Nevertheless, antisocial personality disorder is the most common specific personality disorder found among prisoners, with a prevalence rate of 50% (Coid et al., 2009).

Biological and genetic associations are reported for antisocial personality disorder. Differences in volume of the prefrontal cortex may explain the reduction of controlling aggressive impulses. In a review, Ferguson (2010) indicates that deficits in the frontal lobes and lesions in the frontal cortex are associated with aggression. Genes have been identified that appear to interact and increase susceptibility of exhibiting antisocial behaviour, aggression and violence; such as the 5-HTT serotonin transporter promoter gene and a low-MAOA activity genotype. Overall, Ferguson (2010) found that 56% of variance in antisocial personality and behaviour is genetically explained. Brain disease or brain trauma can result in personality change. This physical aetiology is important as both the DSM and ICD differentiate between personality disorder and personality change, with the latter excluded from personality disorder sections in the nosologies. The information contained in this report is specifically in regard to personality disorders.

In terms of environmental risk factors, economic disadvantage, neighbourhood violence and deviant peer group attachment, as well as childhood abuse, are implicated in the development of antisocial personality disorder (Beauchaine et al., 2009), as well as maternal rejection, poor parenting behaviour, presence of attention deficit hyperactivity disorder and low income (NICE, 2009).

It is widely accepted that childhood abuse, trauma and neglect is associated with antisocial personality disorder, however environmental risk factors alone do not account for development of antisocial personality disorder. As with borderline personality disorder, they combine with genetic and biological risk factors to manifest in the disorder. It has been proposed that the aetiology overlaps with that of borderline personality disorder, and that the two disorders are indicative of the same underlying phenomenon that is expressed differently in males and females (Beauchaine et al., 2009), which may have implications for treatment. For example, both disorders have high rates of suicide and are characterised by impulsivity; and both are highly comorbid.

Personality disorders often occur with other syndromes and disorders. It must be noted that one of the most common comorbid conditions in antisocial personality disorder and borderline personality disorder involves alcohol/substance use difficulties. Provision of existing services for drug/alcohol disorders should be targeted for training and interactive treatment planning.

Studies of resilience provide information that can be used to target treatment, intervention and prevention of antisocial personality disorder. In a review of studies into resilience following childhood maltreatment, Afifi and MacMillan (2011) found that stable family environment and supportive relationships following maltreatment are protective and resilience factors for many adverse outcomes. At individual level, protective factors include personal characteristics, coping skills, appraisal of maltreatment and self-efficacy. Community factors include positive peer relationships and non-family social support. NICE guidelines for antisocial personality disorder provide evidence and recommendations for intervention strategies at childhood levels.

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# SECTION D

## Treatment approaches for personality disorder

A diagnosis of personality disorder is likely to be provided in clinical or forensic settings, therefore initial targeted treatment is less likely to be provided at primary care level, as individuals presenting with personality difficulties are likely to be referred to specific mental health services for assessment, diagnosis and treatment. Moreover, the nature of some personality disorders dictates less likelihood of treatment seeking or self-awareness, and referral or treatment often follow crisis presentations at accident and emergency departments. Information gathering is essential at these points for adequate management and treatment of individuals in crisis. Education for front-line staff, not only in accident and emergency departments but across a range of health, forensic and community services regarding personality disorders and the interpersonal difficulties associated with them, is essential for providing useful and targeted interventions and avoiding those that may exacerbate problems.

The levels of comorbidity and the complexity of personality disorders discussed in Section C also dictate the treatment provided. At present there are no established specific personality disorder treatment services in Northern Ireland. Individuals with this type of disorder are treated within the existing mental health and forensic services, or travel to England or Scotland for specialist treatment and intervention.

Shannon Clinic in the Belfast Health and Social Care Trust is the regional medium secure unit and provides intensive psychiatric treatment and rehabilitation services for individuals with complex mental difficulties within a health and forensic setting. However, specific management services and units for personality disorders are required, as some interventions and management systems provided for other mental disorders may be detrimental to individuals with personality disorder, reinforcing negative beliefs and exacerbating the impact of the disorder, and resulting in likelihood of lengthier or repeated service use.

Establishing evidence based practice for treatment and management of personality disorders is problematic as the complexity of personality disorder presentation, its measurement and the high levels of comorbidity ensure difficulties exist. Traditionally within psychiatric settings, pharmacological treatment has been used to target specific symptomology such as anxiety, psychosis and mood symptoms rather than the provision of a specific personality disorder treatment. Within psychological settings, overall well-being and reduction in distress or provision of coping skills through psychological therapy is more likely.

### *Pharmacology*

Pharmacological interventions for symptoms of personality disorder can be tailored according to the biological systems involved. Lara and Akiskall (2006) suggest that personality disorders share a neurobiological substratum with mood and behavior disorders based on combinations of fear and anger traits. For example, anxiolytics and

antidepressants may restrain fear, and antipsychotics and mood stabilizers may reduce anger.

One Cochrane review was found for pharmacotherapy in antisocial personality disorder. Khalifa et al. (2010) suggest there was some evidence that the depression treatment, nortriptyline, could help reduce misuse of alcohol in individuals with antisocial personality disorder, and that the epilepsy drug, phenytoin, could help reduce intensity of impulsive aggressive acts, but these drugs are no longer widely used. Nonetheless the authors state that overall, evidence for pharmacotherapy in antisocial personality disorder was insufficient to provide any conclusions.

In terms of evidence for pharmacotherapy for personality disorders, most reports relate to borderline personality disorder. In a systematic review of pharmacological treatments for personality disorders, Paris (2011) found that most publications were in regard to borderline personality disorder and then focused the review on them. Clearly, further research and trials are required for the remaining personality disorders.

Antidepressants are used in personality disorder for symptoms such as mood and emotional difficulties. Tricyclics and mono-amine oxidase inhibitors (MOAIs) were used for treating depressive symptoms; however side-effects of non-compliance and danger of overdose due to the small amount required for fatality led to an increase in use of specific serotonin reuptake inhibitors (SSRIs) which are safer and more widely used for borderline personality disorder symptoms, said to 'take the edge off' anger and aggression (Paris, 2011).

Furthermore, mood stabilizers (antiepileptic) are also used in borderline personality disorders to reduce impulsivity with small trials indicating reduction of anger. Overall this type of medication may be useful in reducing impulsivity and aggression, although larger replication studies are necessary before any recommendations can be made (Paris, 2011).

Antipsychotic medication has also been used in low dosage in borderline personality disorder, and as with mood stabilizers, are recently more popular than SSRIs (although this effect may be due to fewer trials of SSRIs in the last number of years) (Feurino and Silk, 2011). Although short-term reductions in impulsivity have been reported for antipsychotics in some trials, there are no reports of maintenance at six-month follow ups, and such medications can have serious side effects after treatment of several months – so are unsuitable for long-term personality disorder symptoms (Paris, 2011).

In regard to borderline personality disorder, Paris' (2011) review of publications and randomized clinical trials produced three overall conclusions regarding the use of antidepressants, mood stabilizers and antipsychotics. (1) Drugs still need to be prescribed due to the difficulty of controlling symptoms of borderline personality disorder, although there is not enough evidence of specific effects from specific drugs. (2) None of the drug types produce remission of borderline personality disorder and caution is encouraged for their use. (3) Choice of biological treatment is still trial and error due to lack of evidence and should be viewed as partial treatment rather than the main approach.

In agreement, Feurino and Silk (2011) also indicate that the evidence for use of specific pharmacological treatment for borderline personality disorder is uncertain and inconclusive,

although they are still used for treating symptoms. The authors suggest that difficulties in reaching consensus arise from the limitations of small trial sizes, differences in outcome measures across trials and lack of inclusion of more severely affected individuals who are most demanding and challenging.

The general agreement across reviews into pharmacotherapy for borderline personality disorder is that although symptoms often require medication, it is difficult to ascertain which medications are efficacious, and that any used should be in conjunction with psychotherapeutic treatments.

### *Psychological therapies*

There is strong evidence that psychotherapies are effective for treating personality disorders as well as improving occupational and social functioning in individuals with such diagnoses. In a systematic review of psychotherapy for personality disorders, Verheul and Herbrink (2007) found evidence that cognitive behaviour, psychodynamic therapy, long-term outpatient and short-term day hospital group and individual therapies are all efficacious. Furthermore, the authors indicate that symptom distress is a motivational factor in successful therapy, however motivational techniques are also likely to be a targeted outcome of treatment for some personality disorders in which impairment and lack of insight is high. This is likely to disadvantage some individuals as motivation to improve/engage is often a precondition or prerequisite for therapy.

In a review of meta-analyses and randomised control trials (RCT) for borderline personality disorder, Cailhol et al. (2011) found that dialectal behaviour therapy (DBT) has the best documented efficacy, especially for self-mutilating and suicidal behaviours, mentalisation based therapy (MBT) is also efficient, however only one RCT was reported. In addition, manual assisted cognitive treatment (MACT) and systems training for emotional predictability and problem-solving (STEPPS) are most cost effective and easily implemented.

Efficacy for DBT is also provided in a meta-analysis, with notable effects for individuals who have engaged in suicidal and self-injury behaviours when compared to treatment as usual, although no differences are reported between DBT and other treatments specifically targeted for BPD within analysis including transference-focused psychotherapy (Kleim, Kröger and Kosfelder, 2010).

Schema Therapy has been gaining in popularity for treating borderline personality disorder. RCTs have been published for this treatment with positive results (for example, Farrell, Shaw and Webber, 2009), and it has been shown to be less costly and more effective than transference focused therapy (Asset et al., 2008). However numbers of RCTs are low for this treatment; more RTCs and meta-analysis reports for this treatment would provide more support and evidence for its value.

The Australian Psychological Society (APS) has indicated in a literature review of psychological treatments (APS, 2010) that there is evidence for the efficacy of DBT, schema therapy and psychodynamic therapy.

In a qualitative review of 33 RCTs, over half of which were for borderline personality disorder and none reported for Cluster A disorders, Dixon-Gordon, Turner and Chapman (2011) found four common principles spanning across effective treatments for personality disorders. (1) Therapy on a longer term may be necessary, although there may be differing optimal durations across clusters of disorders. (2) Therapeutic alliance is linked to success of treatment. (3) Improving accuracy in cognition, particularly in interpersonal situations, is an important element across treatments. (4) There is a focus on emotions and emotional regulation. The authors found that DBT is a well-established efficacious treatment for borderline personality disorder. Furthermore, not enough evidence is available for antisocial personality disorder, especially considering the high costs of this disorder to society. In addition, recommendations for future research include establishment of relevant outcomes for antisocial personality disorder treatment – not only recidivism, substance use and aggression, but also suicidal behaviour, depression and other mental health difficulties (Dixon-Gordon, Turner and Chapman, 2011).

Overall, the current evidence is similar to that available for the development of NICE guidelines in 2009 for borderline and antisocial personality disorders. For both, no pharmacological treatment is recommended, as is the case in USA and Europe. For borderline personality disorder, NICE (2009b) recommends that no drug treatment should be used specifically for borderline personality disorder or for its individual symptoms. It may however be considered in treatment of comorbid conditions, and individuals with borderline personality disorder on medication with no comorbid mental or physical illness should be reviewed with the aim of reducing and stopping drug treatment. In crisis situations, no drug treatment is recommended, however under cautious consideration, use of a minimum dose of sedative medication may be made for the short-term (no more than one week) as part of an overall treatment plan. For psychological treatment, an explicit and integrated theoretical approach should be implemented by the therapist and treatment team, with twice-weekly sessions considered especially for more severe and highly comorbid cases. The guidelines also suggest that a comprehensive DBT programme should be considered for women with borderline personality disorder when self-harm reduction is priority.

For antisocial personality disorder, NICE (2009a) recommend that group-based cognitive and behavioural interventions should be considered for individuals with antisocial personality disorder to address impulsivity, antisocial behaviour and interpersonal difficulties within community mental health services and within community or institutional care for those with a history of offending to reduce offending and antisocial behaviour. For dangerous and severe personality disorder or psychopathy, cognitive and behavioural interventions such as Reasoning and Rehabilitation should be considered. Pharmacological interventions are not recommended for treating antisocial personality disorder or associated aggression, anger and impulsivity. As with borderline, individuals with antisocial personality disorder, dangerous and severe personality disorder or psychopathy that also have comorbid mental disorders should receive treatment in line with NICE recommendations for the specific comorbid disorder, including those with drug and alcohol problems.

On a global perspective, other guidelines appear to support the use of medication in personality disorders. In a systematic review, a task force for the World Federation of Societies of Biological Psychiatry (WFSBP) provides detailed guidelines for pharmacological

treatments that are used for personality disorders in order to “help the clinician to evaluate the efficacy… and therefore select the drug best suited to the specific psychopathology of an individual patient diagnosed for a personality disorder” (Herppertz et al., 2007). However, individuals with severe personality disorder or high levels of comorbidity or suicidality are unlikely to be included in any of the studies included (ibid.), which may limit the guidelines for treating and managing individuals with complex and difficult presentations.

## *Conclusion*

Overall the evidence for personality disorder treatment is generally focused on borderline disorder. Evidence for pharmacological treatment for specific personality disorder(s) is lacking, with NICE (2009 *a*&*b*) guidelines for clinical treatment recommending that no drug should be used specifically for treating borderline and antisocial personality disorders or their symptoms. However pharmacological interventions for comorbid disorders are recommended in individuals with personality disorders, and the WRSBP provides guidelines and overall summaries of a range of psychotropic medications currently in use. Psychological therapies are widely accepted as the most efficacious treatment for personality disorders; however there is a lack of comparative evidence. Recommendations are provided that encourage explicit and integrative approaches to therapy and team management of these disorders. Dialectical behavior therapy has been most reported, with encouraging results particularly for suicidal and self-harm behaviours in personality disorder, and recent evidence suggests that Schema Therapy is successful for treating borderline personality disorder. However, caution is recommended as many trials have been carried out in settings that follow full and specific guidelines for the developed therapies, whereas NHS clinical psychologists are encouraged to use a mixture of approaches based on the formulation of the client’s presentation rather than adhering to any specific therapeutic approach (NICE, 2009b).

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# SECTION E

## Good practice, staff characteristics and compositions

According to the most recent Service Framework for Mental Health and Wellbeing document (DHSSPS, 2011), a "person presenting with clinically problematic personality disorder should have a comprehensive mental health assessment including an assessment of risk… and be referred for specialist personality disorder assessment, …should have access to a range of appropriate treatments and care according to their individual needs and access to education, advice, support and management delivered by a specialist, regional personality disorder service as appropriate" (DHSSPS, 2011, p.182). In addition, individuals should have an integrated care pathway implemented in partnership with the HSC, primary care, and carers (standard 19, DHSSPS, 2011). However, although the service framework provides such recommendations and standards, funding for implementation is limited.

The final purpose of this review is to provide information regarding current personality disorder services for consideration in decision making for the establishment of specialist services in Northern Ireland. There has been a growth in the provision of personality disorder services in England and Scotland from which information and lessons regarding good practice can be obtained. The Scottish Personality Disorder Network and the 'Learning the Lessons' report into 11 pilot community services in England (Crawford, 2007) and three pilot forensic services in England (Moran et al., 2008) provide the most useful resources for practice in Britain, and information has been provided from these resources as they are most relevant in terms of service provision, commissioning and the NHS structures involved. These were selected on the basis that they serve populations which are somewhat similar to Northern Ireland.

Following a review of the management and treatment of people with personality disorder in Scotland, the Scottish Personality Disorder Network was established in January 2006. The network has grown considerably and is developing an Integrated Care Pathway for Borderline Personality Disorder alongside NHS Quality Improvement Scotland (details available at www.icptoolkit.org). This specifies that for successful implementation of integrated pathways for borderline personality disorder, generic training programmes are necessary for all staff in contact with people with such a condition so that empathy and understanding is promoted, and principles of working with individuals with personality disorder can be implemented across services and care levels. Furthermore universal assessments and measurements allow for comparisons and dissemination of outcome results and are necessary for evidencing relevant change. In research, meta-analyses and reviews of clinical trials are often hindered due to the difficulties in synthesising differences in diagnostic tools and differences in specified treatment outcomes across specific trials. The lack of approved, universal outcome measures therefore continues to hinder research in this area.

One example is provided that is relevant to Northern Ireland in terms of low resources and the initial setting up and developing of services.

The Dumfries and Galloway Personality Disorder Service initially began as a multidisciplinary group (including service users) meeting approximately every 4-6 weeks. Initially, an audit into the number of people with personality disorders in the area was carried out, with one in four of the total client population, many having been seen by more than one element of service provision. A training needs analysis was carried out also, as well as plans for building maps through care services for frequent service users. The group is involved in developing the Integrated Care Pathway (ICP) for borderline personality disorder, in addition to best practice guidelines (Stirling and MacKenzie, 2010).

At present the team consists of four staff on a one-day per week basis. The team consists of one clinical psychologist, one psychiatrist, one occupational therapist and one community psychiatric nurse, and they are provided with support from management and administration. Due to limited resources the team provide education, consultation and supervision; providing two levels of tailored training through half day workshops to NHS staff, the voluntary sector and other services such as the police. To date 59 people have been trained from across fields such as nursing, social work, support work and addictions counselling (MacKenzie and Gregory, 2011).

Although there are no formal evaluations available for this particular service, it indicates the good use of limited resources allocated for use in the area of personality disorders. However it must be noted that experience of delivering specialist treatment or management of personality disorders is likely to be expected and preferred by individuals and groups receiving training. (This is addressed in the Knowledge and Understanding Framework (KUF) section below.)

A further example provides information of a population base similar to the Northern Health and Social Care Trust (which is approximately 460,000). Beginning as one of the pilot personality disorder services, the Cambridge and Peterborough Service involves two specialist services for personality disorder within the Cambridge and Peterborough NHS Foundation Trust. The team in the Cambridge Complex Cases Service is led by a consultant psychotherapist and includes a consultant psychiatrist in psychotherapy, a senior adult psychotherapist, a senior clinical psychologist, an assistant psychologist, a social worker, an occupational therapist, a probation officer, a music therapist, three psychotherapists (all providing varied time and provision of sessions) and a half-time administrative support worker.

This team covers an area with three primary care trusts and a population of approximately 300,000 people. They cater for approximately 25 adult service users at the higher range of severity, and offer individual therapy (cognitive analytic therapy) and small group therapies including music therapy. A life skills group, mothers group (with a crèche), and a bodies and minds group also provide support for individuals to learn new skills and relevant support. A one-hour open clinic is provided each morning during which individuals are guaranteed to be seen or spoken to if they telephone, and evening telephone clinics run for three hours two nights per week. Service users also run a chat forum on the service website. With the wide ranging services available, staff members are required to be flexible in their roles.

The Peterborough service provides ‘spoke’ functions, with 2.3 full-time staff serving a population of 200,000 people. It has a limited capacity to provide therapy, however there is

a small but intensive service providing psychotherapy for seven users based on 18 month durations. The service developed consultation and training clinics to provide mental health and social care staff regarding psychodynamic assessment, presentation and management of personality disorder. The service also provides monthly personality disorder focused supervision to principal teams in the trust.

Personality disorder services vary widely in terms of scope, resources and development, with a lack of evidence available regarding the impact that these services have on other service use. However, Crawford et al. (2007) examined 11 pilot services for personality disorder to 'learn lessons' about how services are organised, provide therapy and other features that result in good, high-quality practice and care for individuals who have traditionally been let down by services. The authors provide overall summaries regarding staffing, budgeting, involvement with other services and user experience and input (Crawford et al., 2007), an overview of which follows.

Staff recruitment was a challenge during set-up phases of services as many people were unsuitable for working with individuals with personality disorder. However, once established, levels of staff turnover were less than expected. Personal qualities were deemed to be more important than professional qualifications for dealing with clients. Emotional maturity, high personal resilience, the ability to work in a team, and ability to accept own limitations are staff characteristics that were deemed high in priority. Staff members were often required to proactively help provide and incorporate measures for solving practical and social problems. Leaders of personality disorder services had to fill a number of roles, including the provision of consistency and containment for frontline staff, clinical supervision and operational management. The set-up period often lasted longer than expected, taking years rather than months, and affected staff morale (most likely due to the uncertain nature of any pilot service). Good team work and team building was essential in overcoming this. Building up a cohort of clients was difficult, especially for the provision of group therapies, and the requirement of taking time to establish consistency, trust and positive attachment for this particularly cautious or wary client group contributed to lengthy establishment periods for services.

The slow process of recruitment of suitable staff creates difficulties in terms of budgets and funding management. Long-term funding information is important for dealing with services that need to provide long-term treatment. Furthermore, management time and clinical supervision of staff is essential, and many individuals were working in services part-time or simultaneously with responsibilities in other service areas due to staffing and funding difficulties. Formal analyses of needs and evidence of use of services such as accident and emergency, inpatient services, psychiatric intensive care units and referrals to specialist services elsewhere provides a basis on which to make decisions regarding service requirements and funding allocation. There are difficulties in evidencing cost-effectiveness of specialist personality disorder services as it is likely to cover policing, housing, probation and forensic services. These are beyond the scope of personality disorder service remits, yet savings are likely. Pathways to care should be coordinated across local areas and services, and funding and commissioning could also reflect this.

Engagement with other services (including existing mental health services) was not always easy in the initial stages, as some other providers were concerned that their services would

appear inadequate or surplus to requirements. Low referral rates were also reported due to uncertainty about the service, and there was a preference among referrers that personality disorder services should have been more involved in raising awareness and that assessments, advice on management and, in some cases, supervision could be provided. Engagement with local health, social care, third sector and frontline services to promote specialist personality disorder education, training and awareness helped establish good working relationships.

Inputs from service users and carers were vital in the set-up, development and continued review of specialist personality disorder services. Users reported that practical help for managing social problems, and (although often initially most dreaded) group therapy and peer support were important to them.

Interventions for individuals with antisocial personality disorder and complex significant needs were not provided by the pilot services reported by Crawford et al. (2007), and there is uncertainty regarding how services can work with individuals with such complex presentations. However, personality disorder services should provide support, albeit probably separate from those with other personality disorders.

Moran et al. (2008) provide an early report on three pilot personality disorder services in forensic settings. While acknowledging the difficulty of evaluation within a short follow up time, some issues were highlighted that have parallels with setting up community and clinical personality disorder services. Staff recruitment and retention was difficult, with professional qualifications providing little prediction of suitability for posts. Staff characteristics such as emotional resilience and having clear and personal boundaries as well as the ability to communicate well with this client population were seen as most important. The complex interpersonal problems and mechanisms present in individuals with personality disorders are often exacerbated in forensic settings and there is the danger, risk and capability of violent and criminal behaviour towards staff and clients, therefore it can be difficult to recruit and retain suitable staff members. Furthermore, team leaders (usually clinicians) required more administrative support due to difficult workloads during the service setup and development process alongside clinical duties and staff supervision roles.

The pilot forensic service providers also indicated that less time consuming assessment information gathering would be preferred, using agreed universal tools, as at the time of reporting the necessity for some measures were questioned. For example, six assessment tools as well as two versions of the Psychopathy Checklist are recommended in the government planning and development guidelines (Department of Health, 2005) and implemented as part of assessment for treatment in the pilot studies.

Service providers indicate that a full programme of activities is required in service provision. In particular drug and alcohol treatment modules were required and provision of clear self-harm intervention guidelines. Establishment of links to local services was recommended. Awareness of continuing assessment and auditing was present, however the authors state that the database for assessments should be refined, and information should be pooled from across the services. There was no communication between pilot services due to time and distance constraints, although providers stated they thought this would have been useful.

The staff composition of the pilot medium secure service for individuals with personality disorder is provided from the Oswin Unit in Northumberland, Tyne and Wear Forensic Personality Disorder Service. This example is provided, as it covers a population of 1.4 million, slightly less than the Northern Ireland population of 1.8 million. There is provision of 16 beds, and staff members are 42 nurses, four occupational therapists, three psychologists, two assistant psychologists, three administrative staff, 1.5 staff grade doctors, one psychiatrist, one social worker, one physiotherapist, one teacher, one technical instructor and a half time psychotherapist. Staff characteristics of being "solid, dependable and robust" (Moran et al., 2008, p.103) were considered to be required and predictive of suitability to that service. Team leadership was an issue in this service, as a 'flat management structure' was in place, creating difficulties in staff morale and clinical decision making. A clinical management group was established that included representations from all staff levels and helped dispel some problems, however there was a desire that a specific leading staff member should be in place.

Lack of information on funding has created uncertainty regarding future and long-term follow up of pilot personality disorder forensic services. This is an issue that should be considered by commissioners of Northern Ireland based services in order to ensure evidence-based practice is in place and subject to review and audit.

Overall, the best practice and staff composition in specialist personality disorder services depends on the funding, resources and staffing available. Findings from the reports on the pilot services support the organising and planning of service guidelines provided by NICE (2009). These indicate that specialist, multidisciplinary services should be provided by mental health trusts and have expertise on diagnosis and management of (borderline) personality disorder. Services should provide assessment, multidisciplinary care plans and treatment; consultation and advice to primary and secondary care services; develop protocols, communication and information sharing across different services and relevant agencies (health, forensic, mental health, social services, criminal justice and voluntary bodies); as well as advice on and access to treatment for comorbid disorders and peer support. They should create protocols and support for transitions from and to prison and long-term treatment, and from child and adolescent to adult services; include service users and carers in development and planning of services; and provide training programmes on the diagnosis and management of personality disorder (NICE, 2009, p. 388).

As previously discussed, individuals with personality disorder require long-term treatment. The characteristics, supervision and supportive management of staff involved in this treatment are of the utmost importance, as stability is often a key target for treatment. Recruitment of suitable staff has been a difficulty for some pilot services, and should be treated as priority in service development to avoid unnecessary delays in provision. As with many psychological treatments, evidence shows the importance of the therapeutic alliance between client and health professional. Specialist treatment centres that provide long-term residential, in-patient, day-patient and out-patient services are required for clinical, community and forensic clients.

***Knowledge and Understanding (KUF)***

One of the first tasks of developing and implementing specialist personality disorder services is to assess current knowledge and provide awareness and understanding of the disorders and how they affect individuals and their ability to interact with and avail of current services. The Personality Disorder Knowledge and Understanding Framework has been developed and provided by a partnership between the Personality Disorder Institute in Nottingham University, Tavistock and Portman NHS Trust in London, Borderline UK and the Open University. The main goal of this KUF is to "improve service user experience through developing the capabilities, skills and knowledge of the multi-agency workforces in Health, Social Care and Criminal Justice" (Institute of Mental Health, 2009; p.2). The KUF programmes offered consist of three levels: The Virtual Learning Awareness Programme "Raising Awareness" which also includes a "Train the Trainers" version; a validated undergraduate degree "Developing Understanding and Effectiveness"; and a master's degree programme, "Extending Expertise Enhancing Practice". All master's level and undergraduate degree modules are available as stand-alone educational modules. Full information on each of the educational packages is available in the brochure (Institute of Mental Health; 2009) and from the National KUF website (http://www.personalitydisorderkuf.org.uk/). Overall, the awareness training consists of 6 online modules accompanied by three days teaching contact time (the "Train the Trainers" package is an additional three days teaching contact time). The undergraduate degree programme consists of four certificate level modules, three diploma level modules and two degree level modules; and the Master's programme consists of seven modules including the dissertation/project module. Three Master's level modules are required for a Post Graduate Certificate, and six are required for a Post Graduate Diploma.

The Awareness Training package has been provided primarily using online modules for ease of access. The inclusion of a "Train the Trainers" package is to provide training for individuals who have completed the awareness programme who (?) then provide the awareness training to others in their work area. As a first step in the process of change, one cohort of 20 people has availed of this training through the Beeches Training Centre in Belfast at the start of 2012, with a follow-on "Train the Trainers" programme due to take place in May 2012. At present there is no evaluation available for this specific cohort.

However, following the government provision of £64,000 per region in England for KUF training, The East of England KUF Partnership was formed which covers six of seven mental health trust areas. (The seventh is Cambridge and Peterborough which opted out as there were already links and training established there as discussed above.) The East of England KUF Partnership published a report in October 2011 which provides details of setting up the Partnership and roll-out of the training as well as the evaluations and student make-up from the different training courses. It recommends that the training should be continued and is proving highly effective:

> "It is Awareness Training and will not heal all ills, but it has exceeded expectations for most and is providing valuable lessons and changes in practice. Its cost effectiveness is evident in that the intention was for each region to deliver 200 multi-agency students per year for £64,000 per annum. Our region is likely to

> exceed this number, and will maintain further increases, as the initiative continues to cascade." (P.35)
>
> (East of England KUF Partnership, 2011)

Following the initial KUF training provided by the Beeches, provision of funding for training and the establishment of co-ordinated training provision across Northern Ireland is warranted.

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# SECTION F

# Conclusions and recommendations

Personality disorder can be debilitating and frustrating for individuals with this diagnosis, and for their carers and families. It reflects long-standing and deep-rooted problems in functioning and relating to oneself and to others, often with little, if any, insight. Due to lack of awareness and empathy, many individuals have gone undiagnosed and branded as difficult to treat and deal with, receiving inappropriate treatment and presenting repeatedly to services. This has resulted in frustration for clients and service providers.

The two current psychiatric guidelines, the DSM-IV-TR (APA, 2000) and the ICD-10 (WHO, 1992) provide criteria lists for 10 and eight discrete personality disorders respectively. However proposals for new editions involve the shift in focus of categorization to the measurement of pathological traits rather than discrete disorders. This reflects what is currently practiced, as most clinicians treat the symptom cluster in each client rather than specific treatment for the disorder. Proposed changes in the guidelines may also reduce problems in research and evaluations of treatments and services.

Childhood abuse, neglect and economic disadvantage are associated with the development of personality disorders alongside genetic and biological factors. Correlates of personality disorder include drug and alcohol abuse, anxiety and depression. Younger age, unemployment and separation and divorce are more likely in individuals with personality disorder.

There is no evidence for the efficacy of pharmacological treatments for specific personality disorders. Recent evidence supports the conclusion that psychotherapy can be used to treat personality disorders successfully. Dialectical Behaviour Therapy, Schema Therapy and Mentalisation Based Therapy appear to be currently in favour. No specific therapy is recommended over another, but at least one should be provided to clients, and choice is preferred.

Three main questions were addressed in the current review:
1) What are the groups and characteristics of people with personality disorders within community, clinical and forensic settings?
2) What are (a) the treatment approaches for personality disorders in community and prison settings, and (b) their outcomes?
3) What are the staff compositions and characteristics of existing good practice specialist personality disorder services elsewhere?

In examining the answers to these questions, a number of recommendations/points for consideration became apparent. These recommendations are based on the findings from each section of the review. The recommendations cover research, treatment and the development of services. Prioritisation will depend on the resources available, prevalence, cost effectiveness, and level of need.

**Recommendation 1: Research into prevalence rates and existing treatment provision for personality disorder in Northern Ireland should be undertaken.**

As demonstrated in section C, there is a lack of evidence of personality disorder prevalence and treatment in Northern Ireland. In order to develop services and target areas for prevention, intervention, treatment and education and training, prevalence rates should be established and training and needs assessments should be carried out across community and health care settings. Levels of comorbidity and combinations of comorbid disorders should be identified and recorded, as they are likely to be vital for identifying difficulties, treatment planning and management. Such information will provide a baseline for future evaluation of services and interventions.

The benefits to people with personality disorder in contact with initiatives such as the Knowledge and Understanding Framework should be evaluated. This evaluation should include measurement of staff attitudes as well as specific knowledge, skills and competencies where appropriate.

The quality of the specialist personality disorder services provided, in terms of effectiveness, safety and user and carer experience, should be evaluated through compliance with best practice and consistent use of universal outcome measures.

**Recommendation 2**: **Planning, evaluation and service protocols for personality disorder services in Northern Ireland should reflect and inform proposed changes to legislation in Northern Ireland and anticipate proposed changes in the DSM and ICD personality disorder guidelines**.

Section A identifies issues around defining personality disorders within existing legislative frameworks. A lack of specialist personality disorder service provision in Northern Ireland was highlighted in the Bamford Reviews of Mental Health and Learning Disability reports, which made recommendations that specialist personality disorder services should be developed. Provision of such services is particularly relevant to Northern Ireland as there are higher rates of mental health service use (RCP, 2006), and high levels of experience of traumatic events and posttraumatic stress disorder symptomology (Ferry et al., 2008; Bunting et al., 2011), which are highly comorbid with borderline and antisocial personality disorders (Axlerod, Morgan and Southwick, 2005). The legislation surrounding mental health in Northern Ireland has not changed since 1982, and some of it is not in line with changes made in legislation across England and Scotland. The proposed Mental Capacity (Health, Welfare and Finance) Bill for Northern Ireland and proposals for substantial changes in DSM-5 and ICD-11 (psychiatric guidelines) personality disorder sections are published. These are likely to have an impact on diagnosis and service provision.

**Recommendation 3**: **Full economic evaluation of costs of personality disorder across health and social care, housing, policing and other agencies would provide a baseline figure to establish and evaluate targets and intervention strategies.**

Section C highlights the economic impact of personality disorders. Costs associated with personality disorders are higher than for other mental disorders (Crawford, 2007) due to the complex and difficult interpersonal nature of presentations and lack of awareness of staff and agencies regarding these disorders. Building on existing staff skills is likely to be more cost-effective. In addition, prevalence rates from elsewhere provide an indication of the extent of personality disorder and therefore the likelihood of increased associated costs. Personality disorder rates for England, Scotland and Wales are 4.4% (Coid et al., 2006), and a world mental health survey indicates an overall estimated prevalence of 6.1%, with 2.4% in Western Europe and 7.6% in the USA (Huang et al., 2009). In clinical settings, prevalence is increased, and there are high levels of comorbid mental disorders. Personality disorders are likely to be underestimated due to preference for mainstream diagnoses. Rates of clinical inpatient and outpatient prevalence of personality disorder is between 30% and 67% (DHSSPS, 2010; Moran, 2008; Zimmerman, Rothschild and Chelminski, 2005). In prison settings, prevalence rates of personality disorder are highest with between 60%-80% reported (DHSSPS, 2010; Singleton et al., 1998).

**Recommendation 4**: **Training, awareness and support should be provided to staff in mental health services and other services/agencies to highlight the possibility of the presence of personality disorders that may be causing difficulties in interactions with clients.**

Dedicated individuals with the expertise to assess personality disorders and complete a comprehensive psychological assessment should be identified within existing mental health / Primary Care Liaison services.

As demonstrated throughout the review, high comorbidity of mental disorders and personality disorder occurs, and many individuals are unaware of the impact that personality disorder may have across many interpersonal situations.

Training can move from enhancing awareness of many existing staff towards providing specialist training in specific approaches for some staff. This is discussed in detail in section E.

**Recommendation 5**: **Integrated pathways for care should be agreed and developed for health, forensic and prison settings and implemented from an early stage in service development.**

Sections D and E identify the benefits of integrated care pathways. High prevalence and repeated presentations of individuals with personality disorder are seen in clinical settings.

**Recommendation 6**: **Clear transitional pathways should be developed for crossovers between community health and social care and prison, between child and adolescent mental health services and adult mental health services, and for the end of treatment, that include risk management strategies and protocols.**

Following on from recommendation five, protocols should be developed to ensure good communication, information sharing and working relationships across agencies and with clients. These are required in order to provide continuity in care and treatment, and full evaluation and clarity of service and client responsibilities.

**Recommendation 7**: **A range of therapeutic interventions should be developed and made available as part of individual treatment planning, and universal outcome measurements should be included in treatment planning and assessments for evaluation purposes.**

The lack of evidence for efficacy of pharmacological treatments for specific personality disorders is discussed in section D. Recent reviews support the conclusion that psychotherapy can be used to successfully treat personality disorders. Dialectical Behaviour Therapy, Schema Therapy and Mentalisation Based Therapy appear to be currently in favour. No specific therapy is recommended over another, but at least one should be offered to clients, and choice is preferred. Pharmacological treatment for individuals with personality disorder diagnosis is targeted at specific difficulties such as anxiety, psychosis or mood symptoms. Antidepressant, antipsychotic and mood stabilizer medication is often prescribed. Most evidence for drug treatment relates to symptoms in borderline personality disorder and indicates that the medication under research should be used in conjunction with psychological therapy. However, review and meta-analysis evidence indicates there is no efficacy of pharmacological treatments for personality disorders. NICE (2009a; 2009b) guidelines recommend no pharmacological interventions for borderline and antisocial personality disorders and symptoms, except when carefully considered as a short term (no longer than one week) crisis intervention or to treat a comorbid disorder.

Clinical trials indicating the success of dialectical behavior, schema therapy, psychodynamic therapy and transference focused therapy are published for personality disorders. Long term treatment using group and individual therapy is most effective. However further evidence is required to establish which, if any, specific therapy is superior for particular personality disorders. Symptom distress is a motivational factor in successful therapy, however motivational techniques are also likely to be a successful outcome of therapy for some personality disorders in which impairment is high, which may disadvantage some individuals, as motivation is often a precondition or prerequisite for therapy, so better screening for such disorders is necessary. Clear universal and person-specific outcome measures are required, such as symptom alleviation as well as other measures of improvement such as interpersonal improvements, reduced self-harm, reduced use of emergency services and admissions, improved occupational functioning, and increased efficacy and quality of life.

**Recommendation 8**: **Workforce planning in the area of personality disorder should include substantial focus on the suitable personal qualities of staff, and the provision of good clinical supervision and support management systems for staff.**

In a field where staff turnover and burnout can be problematic for teams and detrimental to clients with high sensitivity to change in personnel, a supportive working environment and staff characteristics of people working with individuals with personality disorder are

considered extremely important. Emphasis and priority are placed on emotional maturity, personal resilience, ability to work in a team and acceptance of one's own limitations, as well as being solid, dependable and robust. Evidence from pilot services outlined in section E, indicates the importance of these staff characteristics in specialist personality disorder teams. Careful consideration of these should be given during recruitment stages.

**Recommendation 9**: **Specialist personality disorder teams should include a broad range of disciplines and skills that can be used to provide expertise and choice of therapy treatments, interventions and skills training.**

Staff composition of specialist teams varies, depending on the numbers involved; however multidisciplinary teams are most successful, with a wide range of skills and talents to provide choice for therapy, group work and skills development. These are a key feature of the examples identified in section E of the review.

**Recommendation 10**: **Clear and immediate support should be provided to ensure speedy set-up and implementation of specialist personality disorder teams in Northern Ireland.**

Evidence regarding the lengthy duration of development of specialist services is provided from pilot services in England (discussed in section E). Interventions and incentives such as government funding and high profile recruitment strategies will help provide personality disorder services in the shorter term.

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